**U.S. Department of Labor**

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

**Issue Date: 23 June 2005**

Case No. 2003-BLA-5705

In the Matter of:
HELEN H. YONCE, Widow of
REX C. YONCE,
Claimant,

v.

CSX TRANSPORTATION, INC.,
Employer,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:
Mark L. Ford, Esq.
On behalf of Claimant

Rodney L. Baker, II, Esq.
On behalf of Employer

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

## DECISION AND ORDER – AWARD OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On April 7, 2003, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 79).[2] A formal hearing on this matter was conducted on October 23, 2003 in London, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

## ISSUES[3]

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner's death was due to pneumoconiosis; and

4. Whether the evidence establishes a change in condition and/or that a mistake was made in the determination of any fact in the prior denial under § 725.310.

(DX 79; Tr. 11-12).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing, Employer was unwilling to withdraw as contested the issues of whether the claim was timely filed, whether the person upon whose death or disability the claim is based was a miner, whether the miner worked as a miner after December 31, 1969, whether the miner worked at least 6 years in or around one or more coal mines, whether the named employer is a Responsible Operator, and whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator. Concerning these issues, Employer submitted no additional evidence. Therefore, at hearing, the undersigned determined that those issues were res judicata under Judge Mosser's and the Benefits Review Board's decision, and not to be considered here. (Tr. 11). Also, partial disability due to pneumoconiosis at the time of death is not considered because the applicable provision of the Act is no longer operative. (Tr. 11). Next, concerning overpayment, the matter remains open pending the outcome of this case, so fault in the creation of overpayment is not addressed here. (Tr. 12; DX 64). Finally, while I noted in hearing that total disability was still an issue, (Tr. 11) total disability is not an issue in a survivor's claim filed on or after January 1, 1982 where there is no miner's claim or the miner was not found entitled to benefits as a result of a claim filed prior to January 1, 1982. §§725.212(a)(3); 725.218(a)(2); 725.222(a)(5); 718.205(a)(2000) (these regulations provide that a survivor is entitled to benefits only where the miner died due to pneumoconiosis, unless the survivor's claim was filed before June 30, 1982). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. §718.205 (c)(2000).

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Rex Yonce ("Miner") married Helen Yonce ("Claimant") in February 4, 1954, and died on October 19, 1998. (DX 19). Claimant testified that they were married at the time of death. (Tr. 18). The parties stipulated and I find that Claimant was an eligible survivor of Miner.

At the hearing, Mrs. Yonce testified that her husband's breathing problems began during the 1970's. (Tr. 19). This condition progressed, and at the end of his life he spit up blood and a lot of sputum. (Tr. 21). Also, his physical activity was limited, at first requiring the use of a cane, but ultimately requiring the use of a wheelchair. Mrs. Yonce also testified that her husband was on a variety of medications for his breathing and other conditions. (Tr, 22-23). Finally, she testified that Miner was in the hospital several times during his last years, including the last 65 days of his life, when he underwent stomach and lung surgery, and a left thoractomy. (Tr. 27).

Procedural History

Miner filed his initial claim for benefits in 1995. (DX 1). Administrative Law Judge Mosser issued a Decision and Order - Awarding Benefits on December 22, 1997. A supplemental Decision and Order denying Employer's motion for reconsideration and awarding attorney's fees was issued on April 28, 1998. Employer appealed these decisions to the Benefits Review Board ("Board") which affirmed Judge Mosser's original benefits decision on May 21, 1999.

Miner died on October 19, 1998. (DX 2). On November 4, 1998, Claimant filed a claim for survivor benefits under the Act. (DX 2). The Director, Office of Workers' Compensation Programs issued a notice of initial determination that Claimant was eligible for benefits under the Black Lung Act on June 23, 1999. (DX 21). On December 28, 2000, Administrative Law Judge Mosser issued a Decision and Order – Denying Benefits. (DX 44). While he found that the Miner had pneumoconiosis, and the condition arose, in part, from coal mine employment, the Miner had failed to prove that his death was due to pneumoconiosis. (DX 44). Claimant appealed, and on January 29, 2002, the Board affirmed Judge Mosser's denial of benefits. (DX 49).

On February 22, 2002, Claimant filed a modification request. (DX 50). On November 5, 2002, the Director issued a Proposed Order to Show Cause Granting the Request for Modification, finding that there had been a mistake in a determination of fact. (DX 71). On December 4, 2002, the Director issued a Proposed Decision and Order Granting Request for Modification, and a Revised Proposed Decision and Order Granting Request for Modification on December 17, 2002. (DX 74-75). In response, Employer timely requested a formal hearing. (DX 76). This matter was transferred to the Office of the Administrative Law Judges on April 7, 2003. (DX 79).

## MEDICAL EVIDENCE

I incorporate by reference, as if fully set forth herein, the medical evidence contained in the Decision and Order issued by Administrative Law Judge Mosser on December 28, 2000. (DX 44). Judge Mosser completely and thoroughly summarized all medical evidence of record from the time Claimant filed her first application for benefits until the Decision and Order in 2000. Therefore, I will not disturb the factual descriptions of the original evidence, but will refer to it as necessary to resolve the modification issue now before me.

Under §725.2 (c), §725.310 of the amended regulations, concerning limitations on the submission of medical evidence on modification, does not apply if a claim was pending before January 19, 2001. Also, a claim shall be considered pending on January 19, 2001 if it was not finally denied more than one year prior to that date. §725.2 (c). Claimant originally filed her survivor's claim in 1998. Even though her modification request was filed after the date of the amended regulations, February 22, 2002, this claim would still fall under the pre-amended regulations because, due to this modification request, there has been no final denial. As a result, the evidentiary limitations of §725.310 do not apply.

X-RAYS

| Exhibit | Date of X-ray | Date of Reading | Physician / Credentials | Interpretation |
|---|---|---|---|---|
| DX 72 | 09/26/97 | 10/24/02 | Barrett, BCR[4], B-reader[5] | Negative |
| DX 72 | 10/23/97 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 10/27/97 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 10/28/97 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 10/29/97 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 11/25/97 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 11/28/97 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 02/09/98 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 02/13/98 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 07/29/98 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 72 | 07/28/98 | 10/24/02 | Barrett, BCR, B-reader | Negative |
| DX 69 | 09/15/98 | 09/25/98 | Harron, B-reader | 1/0 ss |
| DX 72 | 09/15/98 | 10/24/02 | Barrett, BCR, B-reader | Negative |

[4] A physician certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[5] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

Narrative Medical Evidence

Dr. William T. Daniel, a radiologist, submitted a letter dated July 28, 2002. (CX 1-2). Dr. Daniel stated that based on a review of "some" of the x-rays and Tomography Studies from the Baptist Regional Medical Center, as well as the autopsy report, that Miner had changes of chronic interstitial lung disease consistent with pneumoconiosis, lung cancer, and COPD. He also noted that Miner's "last exams" showed Metastatic disease in the lymph nodes, in the mediastinum, and in the liver. He opined that due to the superimposed lung disease, changes of pneumoconiosis, which are based on radiology evidence, are more difficult to see. As a result, Dr. Dennis opined that the "original doctors" who diagnosed pneumoconiosis from the chest x-rays were correct, but the "later exam[s]" that failed to diagnose pneumoconiosis were incorrect. Dr. Dennis did not opine as to whether Miner's pneumoconiosis arose from coal mine employment or whether his death was due to pneumoconiosis.

Dr. Anthony Rogers, a Board certified Thoracic Surgeon specializing in surgery and general vascular surgery, submitted a letter dated June 28, 2002. (DX 59). Dr. Rogers stated that he was Miner's treating physician for the years preceding his death, which included performance of a left thoractomy and resection. Dr. Rogers also stated that Miner was totally debilitated by centrallobular emphysema and anthrocosis, and that these conditions "strongly contributed to his deterioration and ultimate death." Dr. Rogers, however, did not mention any specific evidence which he used as the basis for his conclusions, nor did he opine as to whether Miner's condition arose from coal mine employment.

Dr. Abdi Vaezy, an internist, pulmonologist, and B-reader, preformed a medical evidence review, and submitted a report dated June 24, 2002. (DX 59). Dr. Vaezy considered his previous treatment of Miner on several occasions between December 1987 and June 1998, including a bronchoscopy on December 3, 1997, which turned out to be non-diagnostic for cancer. Dr. Vaezy noted, however, that it ultimately turned out that Miner had primary lung cancer that had spread to other parts of his body, and was the main cause of death. Dr. Vaezy also considered Dr. Baker's November 1990 x-ray interpretation (1/0 with small densities in 5/6 parts on x-ray), PFT (mild obstructive impairment), and report that documented 40 years exposure to coal and other dusts, as well as a 10 pack-year history of smoking. Next, Dr. Vaezy reviewed Miner's last admission to the Baptist Medical Center on October 8, 1998, which diagnosed lung cancer as the primary cause of death and pneumoconiosis as a secondary cause. Also, Dr. Vaezy noted that the death certificate listed "black lung" as a contributing cause. Finally, he considered the autopsy report which he opined proves the presence of anthracosis from coal dust exposure and confirms clinical "black lung." Summarizing this evidence, Dr. Vaezy concluded that Miner had pneumoconiosis based on 1) history; 2) x-ray findings; and 3) symptomology. He opined that Miner's terminal illness was "possibly" due to respiratory failure "most likely" resulting in cardio-respiratory arrest, but due to the lung cancer, this information was not specifically documented. Based on all of this information, Dr. Vaezy concluded that Miner "certainly" suffered from pneumoconiosis arising from coal dust exposure, and this condition "certainly" contributed to his death. Dr. Vaezy, however, does not explain how pneumoconiosis contributed to or hastened Mr. Yonce's death.

Dr. Glen R. Baker, Jr., an internist, pulmonologist, and B-reader, submitted an opinion letter dated August 9, 2002 which primarily consisted of a restatement of his October 12, 1995 complete pulmonary examination. (DX 62). Based on an employment history (40 years as a brakeman for the railroad where he was exposed to coal dust), smoking history (10 pack years, quitting in 1982), individual history (ulcers, rheumatoid arthritis, nodule in left lung removed in 1990), symptomatology (chronic bronchitis, cough, sputum production, wheezing, and dyspnea on exertion), an x-ray, (1/0), Dr. Baker diagnosed CWP with a moderate obstructive ventilatory defect and mild resting arterial hypoxemia. Also, he opined that Miner suffered from legal pneumoconiosis manifested in COPD and bronchitis. Dr. Baker went on to summarize a generalized deterioration of Miner's condition over the remaining six to seven years of his life that included both squamous cell lung cancer and adenocarcinoma.[6] Concerning adenocarcinoma, Dr. Baker stated,

> It has been stated that [Miner's] adenocarcinoma may have arisen from a scar from his lung and thus [may] be related to his pneumoconiosis. Pathologists have performed evaluations of the biopsies and thought that he has had changes consistent with pneumoconiosis with pleural and nodal anthracosis being present. [Miner] also had a pleural plaque and with a history to occupational exposure to asbestos, this may be related to asbestos exposure though I did not find a specific anatomical diagnosis of asbestosis of the lungs.

Finally, in Dr. Baker's opinion, "any time [a miner dies of a respiratory death,] coal dust exposure and associated pneumoconiosis [are] considered to be contributing to the cause of death in a significant but non-definable way."

Dr. John M. Watts, a family practitioner, submitted a letter dated August 10, 2002. (DX 66). Dr. Watts stated that Miner was under his care from 1994 through 1998. Based on employment history (40 years with the railroad working around coal, silica, and asbestos), smoking history (10 years total, quitting in the early 1980s), symptomology (breathing difficulties, dyspnea upon exertion, shortness of breath), history (total disability from black lung, central lobular emphysema in 1990 with wedge resection of the lung per Dr. Rogers, prostrate and lung cancer in 1997 resulting in chemotherapy and radiation treatments, coronary artery disease with bypass surgery in 1997), a 1998 autopsy report (showed both squamous cell cancer and adenocarcinoma of the lung), x-ray by Dr. Ray Herron (evidence of both black lung and asbestosis), Miner's medical records, and the DOL's previous denial of benefits, Dr. Watts concluded that CWP hastened Miner's death, and that death was due to complications arising from pneumoconiosis. Dr. Watts noted that 40 years of exposure to coal dust, silica, and asbestos, "which have a cenogenetic [sic] effect on one's health," can "further potentiate" the adverse health effects when combined with cigarette smoking.

Dr. Watts ruled out smoking as the cause of Miner's carcinomas based on the length of time Mr. Yonce smoked and the type of lung cancers he had. He explained that in his practice it is "very unusual to see an individual have lung cancer, much less,… two different primary lung cancers in someone smoking a total of 10 years of his life." Furthermore, he opined that while

[6] I must note that Mr. Yonce only lived three years beyond Dr. Baker's examination, not six to seven. Also, Dr. Baker failed to specify the information he relied upon to summarize Miner's final years.

squamous cell carcinoma is typically the result of smoking, adenocarcinoma is usually associated with other environmental causes, and is "the least likely to arise from smoking." Dr. Watts went on to state that it would be unusual for Miner to develop such severe emphysema from smoking alone base on only a 10 year history. The emphysema, however, could have resulted "solely from CWP or cenogenetically [sic] from coal dust, tobacco and silica over the years." For support, Dr. Watts relied on the medical literature that stated coal dust causes emphysema which is significantly related to mortality, and the probability of mortality from COPD increases the longer a person is exposed to the dust.

Next, Dr. Watts stated that chronic dust exposure results in a gradual decline in lung function from emphysema, which reduces life expectancy. He opined that "[h]ad Mr. Yonce not died from complications arising from the lung cancer, he would have progressive decline in health and life expectancy from emphysema arising out of pneumoconiosis." For support, he noted that Miner was in poor health during the years prior to the cancer diagnosis. Dr. Watts continued by opining that Miner's weakened state, resulting from his combined CWP, emphysema, prostrate cancer, lung cancer, coronary artery disease, and congestive heart failure, resulted in a "poor response to chemotherapy and radiation treatments." Comparing Miner to someone who does not suffer from these conditions, Dr. Watts concluded that since pneumoconiosis works cenogestically [sic] with these other conditions, that his death was hastened by the disease. In summary, Dr. Watts added that "anyone with pneumoconiosis and severity of his emphysema secondary to black lung that Mr. Yonce had, will be compromised and not do as well with chemotherapy."

Dr. William O'Connor, a Board certified anatomic pathologist, submitted a letter dated September 6, 2002. (DX 66). Based on a review of Miner's medical records, autopsy report, autopsy slides, employment history (40 years with the railroad, exposed to coal dust and asbestos), and a minor smoking history (10 pack years), Dr. O'Connor concluded that Miner's "progressive pulmonary deterioration primarily reflected the deleterious consequences of occupational lung disease." He added that Miner's pneumoconiosis complicated the cancer treatment, resulting in limitations on the amount of chemotherapy that could be used to fight the cancer, and eliminating the ability to use radiation therapy. As a result, Dr. O'Connor opined that Mr. Yonce's death was the "result of complications from black lung and supervening multiple lung cancers related to industrial workplace exposure."

Next, Dr. O'Connor turned to explain how the autopsy results supported a finding of pneumoconiosis. First, he opined that the fibrotic antracotic regions, emphysema, and pleural anthracosis that were found upon examination are "hallmarks" of CWP. He noted, however, that pleural plaque, which is symptomatic of asbestosis, was also present. Also, while the results showed none of the "classical findings of simple or complicated coal workers' pneumoconiosis," Dr. Connor explained that due to the two types of lung cancer, much of the parenchyma has been destroyed. He stated, however, that even though this typical evidence of CWP was no longer present, the previous clinical and radiological determinations of the disease remain sufficient to prove its existence. Finally, to address the impact of cigarette smoking, Dr. O'Connor explained that even though emphysema and lung cancer are commonly consequences of cigarette smoking, the literature finds the conditions to be increasingly severe in the case of coal workers, especially if those miners also smoke. In this case, however, Miner had "a very limited cigarette smoking

history." Thus, Dr. O'Connor concluded that it was unusual for Miner to have two types of lung cancer; especially adenocarcinoma, which is not typically associated with cigarette smoking.

Dr. Michael Kelly, an internist and pulmonologist, submitted a letter dated August 2, 2002. (DX 66). Based on a review of Miner's past medical records, which included symptomology (productive cough and progressive dyspnea), history (rheumatoid arthritis, diabetes, myocardial infarction in 1997, prostate cancer diagnosed in 1997, pneumoconiosis, and asbestosis), PFTs (severe restrictive pulmonary disease), x-rays (markings in the lower lungs as early as 1995), pathology reports (adenocarcinoma of the prostate, non-small cell carcinoma of the lung, metastatic adenocarcinoma in the hilar lymph nodes, adenocarcinoma in the right lower lung, interstitial fibrosis in the left lung, pleural plaque in the left lung, and pleural and nodular anthracosis), employment history (40 years with the railroads in conjunction with transportation of coal), cancer treatment history (after diagnosis, he began treatment but was unable to tolerate, completing only six chemotherapy secessions and eight radiation secessions before he succumbed and died), and a history of cigarette smoking, Dr. Kelly concluded that Mr. Yonce suffered from CWP and asbestosis. Concerning smoking, Dr. Kelly stated that while it likely contributed to his COPD, this history would not account for Miner's restrictive defects, or the x-ray and autopsy abnormalities. Finally, with regard to the effect of cigarette smoke, asbestos, and silica associated with coal dust on Miner's death, Dr. Kelly opined that he "succumbed rather quickly to … cancer," and that the underlying medical conditions significantly contributed to the speed of Miner's demise and the aggressiveness of the tumor. He added that people who have these types of cancers typically "survive much longer, respond to therapy, and on occasions can be cured," but due to Miner's "severe pulmonary function limitations, he was unfit for surgical treatment and was unable to respond to the chemotherapy or radiation in a typical fashion."

Dr. Roger McSharry, an internist and pulmonologist, submitted a letter dated October 4, 2002. (DX 69). In preparation, Dr. McSharry reviewed of the letters submitted by Drs. Kelly, O'Connor, Watts, Rogers, and Vaezy, his May 18, 2000 letter and the supporting evidence mentioned therein, and his June 20, 2000 hearing testimony. Concerning Dr. Rogers' June 28, 2002 letter, Dr. McSharry opined that while emphysema impacted Miner's health, the emphysema in this case was related to cigarette smoking and not coal dust exposure. He went on to state that Dr. Rogers' reliance on anthracosis was misplaced in this case because it has no significance physically, it does not cause symptoms in and of itself, and in Dr. McSharry's opinion, did not contribute to Miner's death.

Concerning Dr. Vaezy's June 24, 2002 letter, Dr. McSharry opined that even though the presence of anthracosis in this case is indisputable, it in no way hastened death because anthrocosis is a clinically silent condition. Dr. McSharry went on to reiterate that death was caused by smoking related emphysema and metastic cancer of the lung.

Concerning Dr. Watts' letter dated August 10, 2002, Dr. McSharry opined that since Dr. Watts considered only 10 years of smoking, which was too short a history, this opinion was unreasoned. He also disagreed with Dr. Watts' statement that exposure to coal dust and silica will predispose one to lung cancer. Finally, Dr. McSharry again explained that the autopsy

finding of anthracosis was insignificant without evidence of coal macules or other distortion of lung function.

Concerning Dr. O'Connor's letter dated September 6, 2002, Dr. McSharry explained that Dr. O'Connor was incorrect when he stated that instances of lung cancer were increased in coal workers. Also, Dr. McSharry finds it "inconceivable" that, as Dr. O'Connor contends, every trace of coal workers pneumoconiosis would be eradicated by the presence of cancer. According to Dr. McSharry, "It seems much more likely these lesions were not present to begin with." Next, Dr. McSharry points out that Dr. O'Connor had significantly underestimated Miner's smoking history by considering only 10 years. Finally, Dr. McSharry does not disagree with Dr. O'Connor's opinion that Miner's advanced lung disease limited the therapeutic options for treating cancer, but adds that these pulmonary abnormalities were not the result of coal mine employment.

Concerning Dr. Kelly's letter dated August 2, 2002, Dr. McSharry contends that there is no evidence of restrictive lung disease in this case, but that the reduced vital capacity is related to severe COPD. Also, he opined that the pleural plaques relied upon by Dr. Kelly as evidence of asbestos exposure, are not identical to having asbestosis, and that there are none of the typical findings of asbestosis demonstrated in either the autopsy or biopsy evidence. Turning to Dr. Kelly's opinions concerning anthracosis, Dr. McSharry opined that this condition "in no way can be considered to be a cause of accelerated lung dysfunction, early death from cancer, or responsible for [Miner's] poor responses to chemotherapy." He added that metastatic lung cancer is almost universally fatal, and the length of time a patient survives depends not on the cause of the cancer, but on when it was diagnosed. As a result, Dr. McSharry concluded, "There is no evidence that occupational features have any influence on the 'aggressiveness' of the cancer."

After considering these letters, and his previous review of the medical evidence in this claim, Dr. McSharry concluded that Miner's employment history of exposure to coal dust did not hasten his death. While he acknowledged that Miner had anthracosis, which is a legally accepted form of pneumoconiosis, he emphasized that this condition had nothing to do with Miner's development of lung cancer or emphysema, nor did it hasten his death.

Dr. Joseph J. Renn, an internist, pulmonologist, and B-reader, submitted a letter dated October 10, 2002. (DX 70). Based on his review of the 27 items listed in his report, which included the letters from Drs. Kelly, O'Connor, Watts, Rogers, and McSharry, discussed above, a 75 pack-year history of tobacco smoke exposure, and a 40 year history with the railroads that included hauling coal, Dr. Renn opined that Miner died of acute renal failure. Furthermore, he diagnosed that Miner's adenocarcinoma of the right lower lobe, cavitating squamous cell carcinoma of the right upper lobe, centrilobular emphysema, and chronic bronchitis, were all the result of tobacco smoke. Also, Dr. Renn noted that the pleural plaque was the result of a previous left thoractomy. Finally, Dr. Renn opined that Miner did not have pneumoconiosis, and that his anthracosis, which was the result of a combination effect of tobacco smoking, coal dust

exposure, environmental pollution, and other factors, was benign, and of "no physiologic consequence."[7]

Turning to Claimant's newly submitted letters from physicians, Dr. Renn reviewed and condescendingly berated the opinions of Drs. O'Connor, Kelly, Watts, and Rogers, based on alleged inconsistencies in their reports, contradictory literature that he felt was more accurate than the material they relied upon, their failure to recognize 75 pack-years of smoking history, and the failure to diagnose acute renal failure. Dr. Renn concludes by flatly stating that Miner did not have pneumoconiosis, so pneumoconiosis was neither the cause not contributing factor in his death, and that Miner's death would have been exactly the same even if Miner had never been exposed to coal dust.

Dr. Renn testified at the formal hearing, where he reiterated the conclusions from his earlier written report. He further testified that there was no indication in any of the medical records that Miner was unable to undergo chemotherapy or radiation that would have prolonged his life. (Tr. 49). While he conceded that Miner had anthracosis, Dr. Renn emphasized that anthracosis does not cause pulmonary impairment. (Tr. 53). Dr. Renn's determination of Miner's smoking history came from the January 7, 1990 and March 12, 1990 medical reports, (Tr. 56), and he discounted several of the other physician's opinions because they determined that Miner has smoked for only 10 pack-years, which is "considered to be the bare minimum of tobacco smoking, and does not produce the tobacco smoking diseases that we know about." (Tr. 57-58). When asked his opinions concerning the opinions of Drs. O'Connor, Kelly, Watts, Rogers, and Daniel, he concluded that they were not medically sound or rational. (DX 67). He also stated that when a physician has pathology reports; supplemental x-ray and CT scans are superfluous. (Tr. At 77). But when asked if he reviewed lung tissue slides, conducted his own x-ray interpretations, or looked at the films taken of CT scans, he responded that he had not. (Tr. 68-70). Instead, he testified that he relied on the other physicians' reports concerning the slides, and other physician's interpretations of the x-rays and CT scans, and then used their findings, in combination with the scientific literature, to reach his diagnosis and discredit the other physicians of record. (Tr. 68-70). As in his report, he stated that the final cause of Miner's death was the result of kidney failure. (Tr. 50). When asked whether renal failure was the only cause of death, Dr. Renn responded in the negative, stating that lung cancer, chemotherapy, and hypotension during his radiation oncology visit, all contributed to cause the renal failure. (Tr. 71). Renal failure, he opined, was simply the common pathway that caused his death. (Tr. 71).

Dr. James R. Castle, an internist, pulmonologist, and B-reader, submitted a letter dated November 12, 2002. (DX 73). Based on his review of the October 12, 1995 PFT, the January 29, 2002 decision and order, his June 7, 2000 deposition transcript, Dr. O'Connor's June 9, 2000 deposition transcript, the June 20, 2000 hearing transcript, and the letters from Drs. Kelly, O'Connor, Watts, Rogers, and Vaezy, summarized above, Dr. Castle concluded that Miner's death was not caused by, contributed to, nor hastened in any way by pneumoconiosis, including

[7] For support, Dr. Renn explained that since anthracosis has been found in both Egyptian and Renaissance Italian mummies, and since mummification has traditionally been reserved for the "upper classes, certainly not those who would be involved in coal mining and other dust exposures that would cause anthracosis." I must admit, I am a perplexed by this line of reasoning. Dr. Renn either seems to be saying that anthracosis can be contracted even in the absence of coal dust, or that the "upper classes," "certainly," would not be affiliated with coal mining.

CWP or asbestosis. While Dr. Castle notes that the autopsy materials clearly indicate anthracosis, which does qualify as legal pneumoconiosis, he opined that anthracosis does not cause impairment or disability. He also noted that the pathologists who reviewed the tissues found no evidence of asbestosis or CWP. Next, Dr. Castle stated that it was "absurd" for Drs. Watts, Vaezy, and O'Connor to ignore Miner's statements that he smoked 1 to 1 ½ packs of cigarettes per day for 50 years, and it is also "absurd to presume that one would embellish a smoking history during a time of hospitalization." Concerning Miner's airway obstruction, Dr. Castle stated that since he had only mild degrees of airway obstruction according to the PFTs, this would not result in severe airway obstruction. Also, Dr. Castle opined that Miner's centrilobular emphysema was due to tobacco smoke because CWP causes focal emphysema associated with a coal macule, which was not present in this case. Dr. Castle also concluded that Miner's inability to tolerate the radiation therapy or chemotherapy had nothing to do with any underlying disease, but was the result of suffering two primary, advanced lung cancers, and death would have occurred in a very short period of time regardless of his exposure history. Furthermore, he opined that non-small cell carcinoma and squamous cell carcinoma both occur in the general public at large, particularly among smokers. In the end, Dr. Castle opined that while Miner had evidence of a "very limited form of anthracosis, it did not cause him any disability, impairment, nor did it contribute to, cause, or hasten his death due to lung cancer in any way."

Dr. Castle was deposed on September 16, 2003, where he reiterated the conclusions from his earlier written report. (EX 1). He also affirmed that his review in preparation for the November 23, 2002 report was specifically limited to the reports outlined above, and did not include a personal review of any of the x-ray films or autopsy slides. (EX 1: 29). Also, he added that the existence of lung cancer would not obscure the presence of CWP if it were present. (EX 1: 31).

Smoking History

In neither Judge Mosser's 1997 decision and order awarding living miner benefits, nor his 2000 decision and order denying survivor benefits, does he make a specific credibility finding concerning Miner's smoking history. As a result, it is necessary for the undersigned to review the entire record in order to make a determination of Mr. Yonce's smoking history.

At the November 14, 1990 examination, Dr. Baker recorded that Miner had a 10 pack-year history of smoking. In addition, in his October 12, 1995 report he added that Mr. Yonce smoked from approximately 1972 until 1982. Likewise, on his March 18, 1997 report, Dr. Burki reported a 10 pack-year smoking history, ending in 1982. However, in his June 25, 1997 report, Dr. Burki notated a 75 pack-year history based on a January 7, 1990 report by Dr. Stephen Schindler. But Dr. Burki did not alter his original finding of a 10 pack-year history. On October 24, 1997, Dr. Gary Boliek reported that Miner smoked 1-2 packs per day for 10 years. On March 18, 1990, Dr. Anthony Rogers reported a smoking history of between 1 and 1 ½ packs of cigarettes per day for 50 years, quitting three years earlier. On November 14, 1990, however, Dr. Rogers reported that Miner smoked for 10 years at a rate of one pack per day. On November 29, 1989, Dr. Douglas Rees reported that Miner smoked two packs of cigarettes per day for 50 years. On January 7, 1990, Dr. Stephen Schindler reported that Miner smoked between 1 to 1 ½

packs per day since he was a child, or 70-75 pack-years. On September 2, 1998, Dr. Michael Watts reported that Miner smoked from the ages of 18 to 58, but did not discuss rate. On March 6, 1984, Dr. Sweeney reported that Miner smoked at a rate of one pack per day, but made no mention of the length of smoking history. There were also a number of medical reports that stated that Miner had no smoking history, and several others who submitted medical evidence reviews without ever meeting with the Miner.

While Judge Mosser did not make any specific smoking history conclusion, in his 1997 living miner decision and order, he noted that Dr. Burki's implication of a more extensive smoking history was unsupported by the record, and that he ignored t evidence by ultimately own finding 10 pack-years. Neither Judge Mosser's 2000 decision and order denying survivor's benefits, nor the subsequent Benefits Review Board affirmation, make conclusions, nor base their holdings on any specific smoking history.

The newly submitted medical evidence includes a number of opinions concerning Miner's smoking history. Drs. Vaezy, Baker, Watts, and O'Connor all reported a 10 pack-year history. Drs. Renn and Castle, however, reported a 75 pack-year history. In these recent opinions, Drs. Daniel, Rogers, Kelly, and Mc Sharry did not make a specific finding as to length or amount of smoking, but Dr. McSharry stated that 10 years was an insufficient history.

In response to Employer's 1999 interrogatories Claimant stated that Miner smoked some in 1944 and 1945, but quit. Subsequently, he smoked on an off for a total of approximately eight years, at a rate of one pack per day, but quit around 1980.

Finally, Claimant testified that she never observed Miner smoking upwards of two packs per day for 50 years. (Tr. 18). She stated that he began smoking when he went to World War II, and smoked a little bit when he came back, but he quit on several occasions over the years. (Tr. 28-29). Mrs. Yonce went on to explained that since she "couldn't take the smoke and be around him," and she did not see him smoke very often. (Tr. 29). Also, he did not want her to see him smoke, which also curbed his consumption. However, she also testified that he worked as much as 16 hours per day when he could have smoked. (Tr. 33). Finally, Mrs. Yonce stated that had her husband smoked for 50 years, he would have had to start as a child. (Tr. 31). Knowing his parents, however, she testified that they would not have let him smoke.

In their briefs, the parties propose two conflicting theories to account for the inconsistencies in reported smoking histories. Claimant alleges that Employer's experts are basing their diagnoses on a single, inaccurate, 1990 discharge summary report. (Cl. Br. at 15). She contends that the physician, his assistant, or the transcriptionist might have confused 15 years and 50 years, and in support, Claimant points out that Judge Mosser had to ask Miner to talk louder, at the 1997 hearing. (Cl. Br. at 15-16). Finally, Claimant argues that at no time, at either a deposition or a hearing was Miner asked about his smoking history. (Cl. Br. at 15).

On the other hand, Employer contends that Mrs. Yonce and her late husband lied about his smoking history, noting as significant that Dr. Rogers was not asked to comment concerning smoking history in his latest report, thus, inferring that Claimant was trying to conceal the truth. (Er. Br. at 11, n.5). In addition, Employer alleges, through the testimony of Dr. Castle, that a 75

pack-year history is more accurate than a 10 pack-year history. (DX 73: 18). Dr. Castle argues that while a person will typically try to minimize their smoking history when asked, but at the moment severe health issues arise, they are more likely to give their physician the most accurate smoking history to assist in treatment.

Typically it is my custom to begin with the presumption that a miner would not purposely overstate his smoking history, thereby presenting a possible detriment to his own case. Since the Miner did not testify concerning his smoking history, I am forced to make a determination based on the record, Mrs. Yonce's interrogatory responses, and her hearing testimony. Having found no evidence that Mrs. Yonce was untruthful, I reject Employer's contention, and begin from the perspective that Claimant was telling the truth to the best of her knowledge.

There are basically three types of medical experts involved in this claim. First are the treating physicians who met with Miner in relation to hospitalizations or office visits. Second are those physicians who saw Miner in response to his claim for benefits under the Act. Third are those physicians who have never actually talked to Miner, but have merely reviewed the medical evidence to reach their conclusions. The evidence this third category of physicians relied upon to reach their conclusions was supplied by those physicians in the first two categories. Since a determination of smoking history requires no specific medical expertise, I find that the physicians in this third category are in no better position than the undersigned to make a smoking determination. As a result, these opinions are little more than secondary opinions, and will not be considered concerning the issue of smoking history. The physicians who, according to the record, conduced only a medical evidence review are Drs. O'Connor, Renn, Castle, Kelly, Daniel, and McSharry.[8] Therefore, I will not consider their opinions for determining Miner's length of smoking.

Turning to the examining and treating physicians of record, Drs. Rogers[9], Vaezy, Watts[10], Boliek, Baker[11], and Burki[12] concluded that Miner had a 10 pack-year smoking history. On the

[8] As noted above, Drs. Kelly, Daniel and McSharry did not actually make a specific conclusion concerning length of smoking or rate.

[9] While Dr. Rogers stated on March 18, 1990, that Miner had smoked for 75 pack-years, eight months later he reported only a 10 pack-year history. He also submitted a July 28, 2002 letter, but did not mention a specific length of smoking. Therefore, I find that Dr. Rogers' November 14, 1990 conclusions concerning smoking history are representative of his final opinion.

[10] Dr. Watts' 1998 report stated that Miner smoked from age 18 to age 58, which would span the years 1942 through 1982. In his 2002 report, however, he reported a 10 pack-year history. These statements, while facially inconsistent, can be reconciled when considered in combination with Claimant's response to Employer's 1999 interrogatories and her 2003 testimony. Mrs. Yonce stated that her husband smoked in 1944 and 1945, and testified that he smoked during World War II, but subsequently quit. This is roughly consistent with Dr. Watt's statement that Miner began smoking at 18 years of age. Mrs. Yonce continued by stating that her husband smoked on and off for a total of approximately eight more years at a rate of one pack per day, ending around 1980. This is roughly consistent with Dr. Watts' conclusion that Miner smoked a total to 10 years at a rate of one pack per day, ending in 1982. Therefore, I find that Dr. Watts' reports collectively reflect that Miner had a 10 pack-year smoking history that spanned a 40 year period with intermittent periods when the miner did not smoke.

[11] Dr. Baker's three reports consistently report a 10 pack-year smoking history, but the 1995 report is facially inconsistent with Claimant's testimony and Dr. Watts' report. On October 12, 1995, Dr. Baker reported that Miner smoked from "1972?" to "1982?." The question marks obviously mean that these dates are tentative. Additionally, considering that Dr. Burki reported in 1997 that Miner quit smoking in 1982, it is quite possible that Dr. Baker took a reported ending date and extrapolated a beginning date. Regardless, I find that Dr. Baker

other hand, Drs. Rees and Schindler reported that Miner had a 100 and a 75 pack-year smoking history, respectively. I am persuaded by the reports of Drs. Rogers, Vaezy, Watts, Baker, and Burki that record Miner had a smoking history of 10 pack-years. First, unlike the reports of Drs. Boliek, Rees, and Schindler, these reports were generated in response to black lung litigation. As a result, the physicians were more prone to pay special attention to the issue of smoking history due to its impact on this type of claim. Second, Drs. Rogers, Watts, Baker, and Burki recorded their smoking findings on more than one occasion, or had an opportunity to submit a subsequent report that altered or affirmed their previous findings. Again, this demonstrates the importance that they placed on an accurate smoking history. Third, Drs. Boliek, Rees, and Schindler each submitted single reports as part of hospitalization treatment. Under these circumstances, it reasons that less attention would be paid to precise pack-year history. For instance, if Miner told Dr. Shindler that he smoked for 10 years over a 50 year period at a rate of 1 to 1 ½ packs per day, it would a simple mistake for the physician to record the maximum, 50 years a 1 ½ packs per day. Fourth, Drs. Vaezy, Watts, and to a lesser extent, Dr. Rogers, were all treating physicians who had an opportunity to see Mr. Yonce on multiple occasions and to document and confirm an accurate smoking history, which apparently happened in the case of Drs. Watts and Dr. Rogers who subsequently change Miner's smoking history. Fifth, I am convinced by the fact that even though Dr. Burki noted Dr. Schindler's report of 75 pack-years, he did not change his finding from 10 pack-years.

In summary, I find that since Miner did not testify concerning his smoking history, the undersigned must look to other primary sources, which includes Mrs. Yonce, as well as the physicians who saw Miner first hand. Based on this analysis , I have found that the reported smoking history recorded by Drs. Rogers, Vaezy, Watts, Baker, and Burki are, for the most part, consistent with Claimant's interrogatory responses and testimony. I further find that since the reports of Drs. Rees and Shindler, taken within a two month period, are not supported by follow-up reports by those same physicians, they are less probative than the physicians who saw Miner on multiple occasions and had the opportunity to verify their findings. Therefore, I find that upon consideration of all the evidence in the record, Miner has a 10 pack-year smoking history.

## DISCUSSION AND APPLICABLE LAW

Mrs. Yonce filed her survivor's claim on November 4, 1998. Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

---

consistently found a 10 pack-year history of smoking, but consider his date span equivocal for the purpose of determining when Miner's actual smoking history began and ended.

[12] As noted in Judge Mosser's 1998 living miner decision and order, while Dr. Burki's 1997 report included a notation that Dr. Schindler had reported a 75 pack-year smoking history, Dr. Burki retained his original finding of a 10 pack-year smoking history. This is consistent with his report from April of that same year.

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by § 725.310, provides that upon his or her own initiative, or upon the request of any party on the ground of a change in conditions or because of a mistake in a determination of fact, the deputy commissioner may, at any time prior to one year after the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or a denial of benefits. § 725.310(a) (April 1, 2000).

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). Furthermore, the Sixth Circuit Court of Appeals, under whose appellate jurisdiction this case arises,[13] stated that a modification request need not specify any factual error or change in conditions. *See Consolidation Coal Company v. Director, OWCP [Worrell]*, 27 F.3d 227 (6th Cir. 1994), adopting the Fourth Circuit Court of Appeals standard as set forth in *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993). "A claimant may simply allege that the ultimate fact--disability due to pneumoconiosis--was mistakenly decided, and the deputy commissioner may, if he so chooses, modify the final order on the claim. There is no need for a smoking-gun factual error, changed conditions, or startling new evidence." *Id*.

In determining whether a change in conditions has occurred requiring modification of the prior denial, the Board similarly stated that,

> [T]he Administrative Law Judge is obligated to perform an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial), considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

*Kingery v. Hunt Branch Coal Co.*, BRB No. 92-1418 BLA (Nov. 22, 1994); *See also Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993). Furthermore,

[4] The Benefits Review Board has held that the law of the circuit in which the Miner's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989). The Miner's last coal mine employment took place in the Commonwealth of Kentucky, which falls under the Sixth Circuit's jurisdiction.

> [I]f the newly submitted evidence is sufficient to establish modification . . ., the Administrative Law Judge must consider all of the evidence of record to determine whether Claimant has established entitlement to benefits on the merits of the claim.

*Kovac v. BNCR Mining Corp.*, 14 B.L.R. 1-156 (1990), *modified on recon.*, 16 B.L.R. 1-71 (1992).

Change in Conditions

For purposes of establishing modification, the phrase "change in conditions" refers to a change in the miner's physical condition. *See Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*). Obviously, since Miner was deceased at the time Claimant filed her first survivor claim, she cannot seek modification of the prior denial based on a change in Miner's physical condition. *Kovac,* 14 BLR 1-156, *modified on recon*., 16 BLR 1-156 (1992); *Wojtowicz v. Duquesne Light Co.,* 12 BLR 1-162 (1989). Therefore, in order to be entitled to modification of the prior denial, Claimant must show that a mistake in determination of any fact occurred in the prior denial. *Id.* at 1-71.

Mistake in a Determination of a Fact

Claimant has not alleged that any mistake of fact was present in the decision and order of Administrative Law Judge Mosser. I will review all of the evidence submitted in support of the survivor's claim to determine if a mistake in determination of any fact occurred. In addition to the prior record, Claimant has submitted seven new medical reports, and a more recent chest x-ray interpretation. Employer has responded with three medical reports and 11 interpretations of 11 x-rays.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis:
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue

> to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

**(1)** Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The prior record contained a positive interpretation of the November 11, 1990 chest x-ray by Dr. Baker, a B-reader. It also included five interpretations of the October 12, 1995 film; one interpreted found to be positive for pneumoconiosis by Dr. Baker, and four others read as negative for pneumoconiosis by Drs. Skitz, Wiot, and Barrett, all radiologists and B-readers, and Dr. Paranthamary, a B-reader. Like Judge Mosser, based on these readings, I find the preponderance of the prior x-ray evidence to be negative for the presence of pneumoconiosis.

The newly submitted medical evidence includes a positive interpretation of the September 15, 1998 chest x-ray by Dr. Harron, a B-reader. Dr. Barrett, a radiologist and B-reader, reinterpreted this film as negative for pneumoconiosis. Based on his superior credentials, I accord more weight to the interpretation of Dr. Barrett than the reading by Dr. Harron. As a result, I find the September 15, 1998 film to be negative for pneumoconiosis.

Dr. Barrett also interpreted 11 films dated between September 26, 1997 to July 28, 1998. He interpreted all of these x-rays to be negative for pneumoconiosis. There were no positive readings for any of these films. Therefore, I find them to be negative for the presence of the disease.

I have found that all twelve of the x-rays included in the newly submitted medical evidence are negative for pneumoconiosis. Upon weighing the newly submitted evidence with the prior x-ray evidence, I find the preponderance of the x-ray evidence is negative for the existence of pneumoconiosis. Therefore, I find that Claimant has not proven any type of pneumoconiosis under subsection (a)(1).

**(2)** Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon autopsy evidence. In Judge Mosser's 2000 decision and order, he concluded that based on biopsy evidence from the 1998 living miner's claim, that the miner suffered from centrilobular emphysema anthracosis. Furthermore, since anthracosis is considered pneumoconiosis under §718.201, and the Board did not challenge his conclusions, Judge Mosser found that the

evidence was sufficient to establish the existence of pneumoconiosis under (a)(2). The newly submitted medical evidence does not contest the biopsy findings.

Turning to autopsy evidence, Judge Mosser reviewed pathology reports and reviews by Drs. Desai, O'Connor, Naeye, and Hansbarger, and found that the weight of the evidence was sufficient to support a finding of anthracosis. While Dr, Hansbarger concluded that the anthracotic pigmentation of the lungs was not of a degree sufficient to warrant a diagnosis of CWP, Judge Mosser found that this opinion was outweighed by the opinions of Dr. Desai, who performed the actual autopsy, and Dr. O'Connor. Judge Mosser also noted that while Dr. Naeye attempted to dismiss the significance of anthracosis, his report conceded its existence. As a result, since anthracosis is considered pneumoconiosis under §718.201, Judge Mosser found that the evidence was sufficient to establish the existence of pneumoconiosis under subsection (a)(2). The newly submitted medical evidence does not contest the autopsy findings.

I have reviewed both the autopsy and biopsy evidence, and am in agreement with Judge Mosser's holding. Upon weighing the newly submitted evidence with the prior x-ray evidence, I find the preponderance of the autopsy and biopsy evidence is positive for the presence of anthracosis. Therefore, I find that Claimant has proven the existence of clinical pneumoconiosis under subsection (a)(2).

**(3)** Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

**(4)** The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions.

*Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

In Judge Mosser's 2000 decision and order, he noted that he had previously found the existence of pneumoconiosis pursuant to subsection (a)(4) based on Dr. Baker's 1990 and 1995 examination reports, and Dr. Saha's post-surgery report; a holding that was affirmed by the Board. In addition, Judge Mosser considered reports, depositions, and testimony by Drs. O'Connor, Watts, Castle, and McSharry, in combination with the survivor's claim, and concluded,

> Although some of the physicians are of the opinion that Mr. Yonce did not have pneumoconiosis, I find that the weight of the opinions support an opposite conclusion. I take this position because most of the physicians who did not diagnose pneumoconiosis did acknowledge the existence of anthracosis, but either attempted to dismiss the significance of the condition or attempted to attribute it to something other than coal mine employment. It is true that the significance of the decreased miner's anthracosis is particularly important to the issues relating to the cause of his death. However, Section 718.202 (a)(4) only pertains to the existence of the disease. Since anthracosis fits within the statutory definition of pneumoconiosis, I conclude that the weight of the well-reasoned opinions in this record support the conclusion that Rex Yonce indeed had anthracosis or coal workers' pneumoconiosis at the time of his death.

I have reviewed the previously submitted medical narratives, and I agree with Judge Mosser's conclusion concerning the existence of anthracosis.

The newly submitted medical evidence includes reports, testimony, and deposition evidence by Drs. Castle, McSharry, and Renn, each confirming the presence of anthracosis, but all attempting to downplay its impact on Miner's condition. Furthermore, the reports of Drs. Daniel, Rogers, Vaezy, Baker, Watts, O'Connor, and Kelly all concluded that Miner suffered from anthracosis. There are no newly submitted medical narratives that dispute this conclusion. As a result, I find that none of the newly submitted medical reports disturb Judge Mosser's previous finding of anthracosis, Therefore, I find that Claimant has proven the existence of clinical pneumoconiosis under subsection (a)(4).

Turning to legal pneumoconiosis, in Dr. Baker's 1995 medical report, he diagnosed legal pneumoconiosis manifested as COPD and bronchitis. He based this conclusion on Miner's reduced PFT results. While Judge Mosser did not specifically address whether Miner had legal pneumoconiosis in the 2000 decision and order, his total disability due to pneumoconiosis analysis in the living miner's 1998 decision and order was based on Dr. Baker's opinion. I agree with Judge Mosser's conclusion, and find that this report is well-documented and well-reasoned. Therefore , I accord it probative weight under subsection (a)(4).

Dr. Watts' previous medical narrative evidence also includes a diagnosis of "black lung" based solely on Miner's history. However, since Dr. Watts did not specify the history he relied

upon, his opinion can be given little probative weight for the purpose to determine whether Miner suffers from legal pneumoconiosis under subsection (a)(4).

The newly submitted evidence includes opinions by Drs. Watts and Baker, concluding that Miner suffers from legal pneumoconiosis. On the other hand, it also includes opinions by Drs. Renn and Castle finding that Miner's COPD and emphysema are the result of smoking.

The only explicit diagnosis of legal pneumoconiosis within the newly submitted evidence is that of Dr. Baker. Relying on his objective testing from his 1990 and 1995 reports, he concluded that based upon PFT results, Miner had COPD and bronchitis due to coal dust exposure. As before, I find that his newly submitted letter is based on sufficient data to be considered well-documented, and is sufficiently reasoned. Also, bolstered by his credentials as an internist and pulmonologist, I accord Dr. Baker's opinion probative weight.

Dr. Watts stated that Miner's emphysema arose out of coal mine employment. While this is not an explicit diagnosis of legal pneumoconiosis, I find it to be the equivalent. Dr. Watts relied on accurate employment and smoking history, Miner's history of illness, the autopsy report, and x-rays to reach his conclusion. While the undersigned ultimately determined the x-ray evidence to be negative for pneumoconiosis, I find his diagnosis remains well-documented and well-reasoned, based on the additional evidence he considered. Also, while Dr. Watts is neither an internist nor a pulmonologist, I find his opinion to be further bolstered by his status as a treating physician and Dr. Baker's concurrence. Therefore, I find Dr. Watts' opinion is entitled to probative weight.

In converse, Dr. Renn, an internist and pulmonologist, concluded that based on a 75 pack-year smoking history, Miner's centrilobular emphysema and chronic bronchitis could be attributed only to smoking. Previously, however, I found that Miner only had a 10 pack-year history of tobacco smoking. Due to this 65 pack-year overestimation of smoking history, I discount Dr. Renn's conclusions concerning the etiology of Miner's emphysema and bronchitis. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history). Therefore, I find that despite his advanced credentials, Dr. Renn's failure to identify an accurate smoking history renders his report unreasoned, and therefore, entitled to little weight.

Finally Dr. Castle concluded that Miner's emphysema was the result of smoking, and not due to coal mine employment. Like Dr. Renn, however, Dr. Castle found that Miner had a 75 pack-year smoking history. Therefore, I find his opinion is not well-reasoned due to his 65 pack-year overestimation of smoking history, and his failure to explain why he excluded coal dust as a possible cause of Miner's emphysema, and thus, entitled to little weight.

I have found that Dr. Baker's newly submitted report, supported by the data from his 1995 complete pulmonary examination, to be well-documented and well-reasoned, and entitled to probative weight under subsection (a)(4) in determining the existence of legal pneumoconiosis. I have also found Dr. Watts' report to be entitled to probative weight. On the other hand, I have determined that both Dr. Renn's and Dr. Castle's newly submitted reports are insufficiently reasoned due to the fact that they were based on a 75 pack-year smoking history.

Furthermore, since I have found a 10 pack-year smoking history, I find that Dr. Renn's statement that 10 pack-years of smoking history "does not produce the tobacco smoking diseases that we know about," actually supports Dr. Baker's and Watts' findings of legal pneumoconiosis. Therefore, I find that the preponderance of the medical narrative evidence supports a finding that Miner suffered from legal pneumoconiosis.

In summary, pursuant to subsection (a), I have found under subsection (a)(2) and (4), that the preponderance of the autopsy, biopsy, and medical narrative evidence supports a finding of anthracosis, which constitutes clinical pneumoconiosis under §718.202. I have also concluded under subsection (a)(4) that the medical narrative evidence supports a finding of legal pneumoconiosis. In addition, I have concluded that pursuant to subsection (a)(1) the x-ray evidence does not support a finding of either of these forms of pneumoconiosis. Considering all the prior and newly submitted medical evidence in this claim, however, I find that the evidence supporting a finding of anthracosis and legal pneumoconiosis outweighs the negative x-ray findings. As a result, Claimant has proven, by a preponderance of the evidence that Miner suffered from clinical and legal pneumoconiosis under §718.202 (a).

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that Miner's pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* In this case, however, I have found that Miner has only six years of qualifying coal mine employment. As a result, based on the medical evidence of record, the Claimant must establish that Miner's pneumoconiosis arose, "in part" from coal miner employment. §718.203(c).

In Judge Mosser's 2000 decision and order he determined that Dr. Baker opinion was sufficient to attribute Miner's anthracosis to coal mine employment. In addition, he found that while some physicians attempted to attribute the anthracosis to cigarette smoking or other environmental exposures, Dr. Baker's reasoned opinion was sufficient to meet the "in part" burden of §718.205(c).

I have reviewed the prior medical evidence, and concur with Judge Mosser's conclusions. Furthermore, none of the physicians who submitted new reports in conjunction with this modification proceeding, and who also diagnosed anthracosis, attempt to argue that this condition did not arise from coal mine employment. Also, while Drs. Renn, Castle, and McSharry concluded that Miner's emphysema was caused by smoking, Drs. Renn and Castle underestimated Miner's smoking history by 65 pack-years, and Dr. McSharry concluded that 10 pack-years was an insufficient history, inferring that Miner had a much greater smoking history. As a result, I find Drs. Baker's and Watts' opinions to be more probative. Therefore, I find that the preponderance of the prior and newly submitted medical evidence in this claim supports the conclusion that both Miner's clinical and legal pneumoconiosis arose, at least in part, from coal mine employment, and that Judge Mosser did not make a mistake of fact concerning this issue.

Death Due to Pneumoconiosis

Mrs. Yonce has established, by a preponderance of the biopsy, autopsy and narrative opinion evidence, that Miner suffered from clinical and legal pneumoconiosis arising out of coal mine employment. She must now prove that Miner's death was due to pneumoconiosis in order to be entitled to benefits. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that an eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was he cause of the Miner's death, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205(c).

Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5). The presumption set forth in § 718.304 is not applicable because Claimant has not established the presence of complicated pneumoconiosis. Therefore, in order for Claimant to be entitled to benefits, she must show that pneumoconiosis was a direct cause of Miner's death or that pneumoconiosis hastened Miner's death.

In the 2000 decision and order, Judge Mosser determined that Miner's death was not due to pneumoconiosis. While noting that Drs. Watts and O'Connor concluded that Miner's death was due to the condition, he discounted Dr. Watts' opinion because he did not provide any rationale for the decision, and he gave less weight to Dr. O'Connor's opinion because Dr. O'Connor's expertise was limited to pathology, and provided insufficient support for his conclusions. On the other hand, Judge Mosser found the opinions of Drs. Hansbarger, Naeye, Castle and McSharry, stating that pneumoconiosis neither contributed to nor hastened death, well-reasoned, and accepted them as probative. I note, however, that Judge Mosser's conclusions did not distinguish between clinical and legal pneumoconiosis. I further note that Drs. Hansbarger, Naeye, McSharry' and Castle's prior reports primarily addressed whether anthracosis hastened Miner's death, but they did not discuss the impact of Miner's legal pneumoconiosis.

Turning to the newly submitted medical evidence, Drs. Baker, Rogers, O'Connor, Watts, Castle, McSharry, Renn, Kelly, and Vaezy all provided opinions as to Miner's cause of death. Dr. Baker's 2002 report attributed Miner's death, in part, to both clinical and legal pneumoconiosis. Relying on the objective evidence from his 1990 and 1995 reports, he stated, "any time [a miner dies of a respiratory death,] coal dust exposure and associated pneumoconiosis [are] considered to be contributing to the cause of death in a significant but non-

definable way." I find this conclusion concerning death to be unreasoned and undocumented for a couple of reasons. First, an unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). Dr. Baker provided no support for his conclusion, nor did he reference any specific evidence related to Miner's condition subsequent to his 1995 examination, which took place three years prior to Miner's death. Second, a medical opinion based upon generalities, rather than specifically focusing upon the miner's condition, may be rejected. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985). Dr. Baker's use of the words "any time" is far too broad and all-encompassing to accurately relate to Miner's specific circumstances. Furthermore, by saying pneumoconiosis contributed to Miner's death in a "non-definable way," Dr. Baker concedes that there is no specific explanation as to how either clinical or legal pneumoconiosis contributed to or hastened Miner's death. Therefore, I find Dr. Baker's opinion concerning the impact of pneumoconiosis on Miner's death, to be an unsupported medical conclusion based on generalities, and therefore accord it little weight for determining whether Miner's death was due to any type of pneumoconiosis.

Dr. O'Connor's 2002 report states that Miner's "pneumoconiosis" impacted the cancer treatment, and as a result, Miner's death was the "result of complications from black lung and supervening multiple lung cancers related to industrial workplace exposure." Turning to his prior testimony, Dr. O'Connor stated that Miner had clinical black lung, that it contributed to his death, and that the presence of anthracosis is a "hallmark" of CWP. Turning to Dr. Connor's prior deposition testimony, however, he stated that anthracosis is asymptomatic and that it does not cause a decline in lung function. Therefore, I conclude that Dr. O'Connor's multiple opinions of death due to clinical pneumoconiosis are inconsistent, and thus, entitled to little probative weight for determining whether death was due to clinical pneumoconiosis. (*Hopton v. U.S. Steel Corp*., 7 B.L.R. 1-12 (1984)(failure to explain inconsistencies between his two reports rendered the physician's conclusions of little probative weight).

In Dr. Rogers' 2002 report, he opined that Miner's central lobular emphysema and anthrocosis "strongly contributed to his deterioration and ultimate death." Like Dr. Baker, however, Dr. Rogers provides no support for his conclusion, nor did he specifically reference any evidence related to Miner's condition. As a result, I find this opinion to be an unsupported medical conclusion, and therefore, not a well-reasoned diagnosis for the purpose of determining whether Miner's death was due to any type of pneumoconiosis.

In Dr. Vaezy's 2002 report, he stated that Miner's terminal illness was "possibly" due to respiratory failure "most likely" resulting in cardio-respiratory arrest, but due to the lung cancer, this information was not specifically documented. Based on all of this information, Dr. Vaezy concluded that Miner "certainly" suffered from pneumoconiosis arising from coal dust exposure, and this condition "certainly" contributed to his death. An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000) (a physician, who concluded that simple pneumoconiosis "probably" would not disrupt a miner's pulmonary function, was equivocal and insufficient to "rule out" causal nexus as required by 20

C.F.R. §727.203(b)(3)); *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease). I find that Dr. Vaezy's has attempted to link a chain of equivocal conclusions together to support an opinion which he claims to be "certain." Furthermore, while Dr. Vaezy does state that pneumoconiosis contributed to Miner's death, he does not provide an explanation as to how pneumoconiosis contributed to or hastened death. As a result, I find Dr. Vaezy's ultimate conclusion of death due to pneumoconiosis to be unsupported and thus unreasoned. Therefore I accord his opinion little weight for the purpose of determining whether Miner's death was due to any type of pneumoconiosis.

Dr. Kelly considered Miner's medical history, PFT results, x-ray reports, pathology reports, employment history, cancer treatment history, and a history of smoking. Based on this evidence, Dr. Kelly concluded that Miner suffered from CWP, COPD, and asbestosis. He further opined that Miner succumbed more quickly to cancer than he would have absent these conditions. Also, Dr. Kelly found that while Miner suffered from COPD, which was likely related to smoking, this history would not account for his restrictive defects or the x-ray and autopsy abnormalities.

In response to these opinions, Dr. McSharry explained that metastic lung cancer is almost universally fatal, and the length of time a patient survives depends not on the cause of the cancer, but on when it is diagnosed. I note, however, that there is no evidence in the record that Miner's cancer was detected at a late stage. In fact, Dr. Vaezy's 1997 bronchoscopy was non-diagnostic for cancer. Based on this evidence, I find Dr. Kelly's opinion to be more reasoned than Dr. McSharry's, especially since none of the other physicians of record attributed the aggressiveness of Miner's cancer to late diagnosis. As a result, despite the fact that Dr. Kelly relied, in part, on the x-ray evidence to validate the existence of clinical pneumoconiosis, I find there remained objective evidence to support his conclusions. I conclude that Dr. Kelly's opinion is well-documented and well-reasoned, and bolstered by his superior credentials, I find his opinion is entitled to probative weight in the determination of death due to clinical pneumoconiosis.

Dr. Kelly also concluded that COPD contributed to Miner's demise. Based on Dr. Baker's and Dr. Watts' opinions, I previously determined that Miner's COPD was legal pneumoconiosis. Therefore, while Dr. Kelly did not diagnose death due to legal pneumoconiosis, now that I have determined that Miner's COPD was legal pneumoconiosis, I find that Dr. Kelly's opinion provides additional support for the conclusion that death was due to legal pneumoconiosis. Specifically, I find most convincing Dr. Kelly's opinion that due to the "severe pulmonary function limitations," Miner was unfit for surgical treatment.

In Dr. Watts' 2002 report, he states that medical literature supports the conclusion that coal dust causes emphysema which is significantly related to mortality, and the probability of mortality from COPD increases the longer a person is exposed to the dust. He goes on to explain that chronic exposure to dust results in a gradual decline in lung function from emphysema, which reduces life expectancy, and that in the absence of cancer, Miner's health would have progressively declined, leading to a reduced life expectancy. While these statements may be accurate, I find his conclusions to be more of an opinion as to what would have happened in the absence of cancer, as opposed to an opinion of whether Miner's legal pneumoconiosis

contributed to or hastened his death. Therefore, I do not find these comments to be an opinion as to whether death was due to legal pneumoconiosis.

Next, Dr. Watts opined that Miner's weakened state, resulting from his combined CWP, emphysema, prostrate cancer, lung cancer, coronary artery disease, and congestive heart failure, resulted in a "poor response to chemotherapy and radiation treatments. He then compared Miner's response to that of others who do not suffer from these conditions, and concluded that his death was hastened by the disease. Dr. Watts summarized by adding, "anyone with pneumoconiosis and severity of his emphysema secondary to black lung that Mr. Yonce had, will be compromised and not do as well with chemotherapy." In support, I note that the record supports the fact that Miner succumbed to the cancer prior to completing his cancer treatments.

Dr. Watts has corrected the deficiencies Judge Mosser found in the previous decision and order by providing adequate rationale for his conclusion, and as a result, I find his opinion is sufficiently well-reasoned and well-documented. Therefore, bolstered by his status as Miner's treating physician, and the support provided by Dr. Kelly's opinion, I accord Dr. Watts' opinion probative weight for the determination that, in combination with cancer, Miner's death was hastened by both clinical and legal pneumoconiosis.

Based on Dr. McSharry medical evidence review, he concluded that while Miner suffered from anthracosis, this condition was of no significance physically as anthracosis does not cause symptoms in and of itself. Therefore, he opined that Miner's clinical pneumoconiosis did not contribute to his death. Based on the evidence he considered, I find that his opinion concerning clinical pneumoconiosis, bolstered by his credentials as an internist and pulmonologist, to be well-reasoned and well-documented, and therefore entitled to probative weight.

Turning to legal pneumoconiosis, while Dr. McSharry did not specify a definite smoking history in his 2002 report, he did note that 10 years was an insufficient amount. As I have found that Miner actually has a 10 pack year history, I find that Dr. McSharry's conclusion that Miner's emphysema was related solely to smoking to be unsupported by the evidence of record. This is important to the discussion of death due to legal pneumoconiosis due to a number of statements included in Dr. McSharry's report. With regard to Dr. Rogers' letter, Dr. McSharry opined that Miner's smoking induced emphysema impacted his death. Concerning Dr. Vaezy's report, Dr. McSharry stated that death was caused by smoking related emphysema and lung cancer. Finally, discussing Dr. O'Connor's letter, Dr. McSharry admitted that he did not disagree with Dr. O'Connor's opinion that Miner's advanced lung disease limited the therapeutic options for treating cancer. While the undersigned has found Dr. McSharry's conclusions concerning the etiology of Miner's emphysema unreasoned, like Dr. Kelly's above, I find his conclusions concerning the cause of Miner's death actually support a finding of death due to legal pneumoconiosis, and therefore support Dr. Watts' opinion. Again, bolstered by his credentials as an internist and pulmonologist, I find Dr. McSharry's opinions as to Miner's cause of death to be well-reasoned and well-documented, and therefore entitled to probative weight.

Based on a medical evidence review, Dr. Renn opined that Miner died of acute renal failure. Based on this diagnosis and his finding on a 75 pack-year history of cigarette smoking, he discredited all of Miner's physicians' opinions. When pressed, however, he admitted that

lung cancer, chemotherapy, and hypotension during radiation oncology all contributed to the kidney failure. On the other hand, he also testified that there was no indication that Miner was unable to undergo chemotherapy or radiation therapy. It is proper to accord little probative value to a physician's opinion which is inconsistent with his earlier report or testimony. *Brazzale v. Director, OWCP,* 803 F.2d 934 (8th Cir 1986)(a physician's opinion may be found unreasoned given inconsistencies in the physician's testimony and other conflicting opinions of record). By opining that there was no evidence Miner was unable to undergo radiation therapy or chemotherapy, and then stating that chemotherapy and problems during radiation treatments contributed to his death, I find that Dr. Renn's testimony was inconsistent, and as a result, despite his credentials as an internist and pulmonologist, his determination as to the cause of Miner's death is not well-reasoned or well-documented. Therefore, I accord his opinion little weight.

Based on a medical evidence review, Dr. Castle concluded that Miner's death was not caused by anthracosis because anthracosis does not cause impairment or disability. Based on the evidence he reviewed, I find this opinion to be well-reasoned and well-documented, bolstered by his credentials as an internist and pulmonologist, I accord his opinion concerning clinical pneumoconiosis probative weight.

Turning to Dr. Castle's conclusions concerning Miner's centrilobular emphysema, he opined that Miner's difficulties with radiation therapy and chemotherapy had nothing to do with any underlying disease, but was solely the result of the two types of cancer. As a result, Miner's death would have occurred in a very short period of time regardless of his exposure history. In support he noted that according to the PFTs, Miner only had minor degrees of airway obstruction. Based on the evidence he reviewed, I find this opinion to be well-reasoned and well-documented, bolstered by his credentials as an internist and pulmonologist, I accord his opinion concerning legal pneumoconiosis probative weight.

In summary, I have accorded the opinions of Drs. Baker, Rogers, O'Connor, Renn, and Vaezy's, either little or no weight for the purpose of determining whether Miner's death was due to pneumoconiosis. Concerning death due to clinical pneumoconiosis, Judge Mosser found the previously submitted opinions of Drs. Hansbarger, Naeye, McSharry and Castle to be well-reasoned and well-documented, and therefore, entitled to probative weight. I have reviewed this evidence, and agree with Judge Mosser's conclusions. In addition, I have found the newly submitted opinions of Drs. Watts, Kelly, Castle, and McSharry to be well-reasoned and well-documented, and therefore, entitled to probative weight.

Considering all of these opinions, I find that Drs. Hansbarger, Naeye, McSharry, and Castle consistently stated that anthracosis, while qualifying as clinical pneumoconiosis, has no physiologic consequences. On the other hand, Drs. Kelly and Watts concluded that CWP contributed to Miner's death. But they failed to address the contrary opinions regarding the general nature of anthracosis. Furthermore, while there is medical evidence in the record citing empirical research and studies that support Drs. Hansbarger, Naeye, McSharry, and Castle's conclusion concerning anthracosis, there are no references to any research or studies supporting the opinion that anthracosis will contribute to a miner's death. In the end, since the burden of proof is on the Claimant to prove death due to pneumoconiosis, and I find the reasoned opinions

of Drs. Hansbarger, Naeye, McSharry, and Castle are better supported by the objective evidence of record, I conclude that Claimant has failed to satisfy her burden. Therefore, I find that Miner's death was not hastened or contributed to by clinical pneumoconiosis manifested as anthracosis.

Concerning death due to legal pneumoconiosis, neither Judge Mosser, nor the prior physicians' reports specifically addressed whether legal pneumoconiosis hastened or contributed to Miner's death. Turning to the newly submitted evidence, however, I have found Dr. Watts' opinions to be well-reasoned and well-documented, and therefore, entitled to probative weight. I have also found that while Drs. Kelly and McSharry did not diagnose legal pneumoconiosis, they have concluded that death was due, in part, to Miner's emphysema. Since I determined that the preponderance of the evidence supported a finding that Miner's emphysema constituted legal pneumoconiosis, I now find that Dr. Kelly's and McSharry's opinions generally support Dr. Watts' ultimate conclusion. I further note that Dr. Watts was Miner's treating physician, and Dr. Kelly and McSharry are internists and pulmonologists.

On the other hand, while Dr. Castle is an internist and pulmonologist, I do not find his conclusions to be as well-reasoned as those of Dr. Watts. Specifically, by not identifying COPD to be the result of coal dust exposure, he did not provide very much support for his exclusion of centralobuliar as a contributor to Miner's death. Furthermore, while I found that Dr. Castle based his conclusion on objective data, I find Dr. Watts' opinion to be better supported by the record as a whole as above stated.

Therefore, I find that upon consideration of all of the prior and newly submitted evidence, the preponderance of the evidence supports the conclusion that Miner's legal pneumoconiosis - emphysema caused by coal mine employment - hastened or contributed to his death. As a result, while the record before Judge Mosser did not contain sufficient proof that Miner's death was caused by, contributed to, or hastened by clinical or legal pneumoconiosis, in combination with the newly submitted evidence, I find that Claimant has established that Miners death was due to pneumoconiosis under the applicable provision of § 718.205(c). Therefore, I find that based on the newly submitted evidence, that there has been a mistake of fact concerning this issue.

Entitlement

Claimant, Helen Yonce has established that a mistaken determination of fact occurred based on the prior and newly submitted medical reports. She has proven by a preponderance of the evidence that pneumoconiosis arising out of coal mine employment hastened or contributed to her husband's death. Therefore, I find that Mrs. Yonce is entitled to benefits beginning in October 1998, the month that Mr. Yonce died. §725.503(c).

Attorney's Fees

No award of attorney's fees for services to Mrs. Yonce is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Mrs. Yonce's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Claimant. The parties have 10 days following receipt of any

such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See* §§ 725.365 and 725.366.

## ORDER

IT IS ORDERED that the request of Helen Yonce for modification of the December 28, 2000 decision and order – denial of benefits, is GRANTED. IT IS FURTHER ORDERED that the claim of Helen Yonce for benefits under the Act is hereby GRANTED

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

## NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**